4-000 The Basic Benefits Package

4-001 Introduction: 482 NAC 4-000 sets forth the responsibilities of the Primary Care Physician (PCP) and medical/surgical plan in delivering the Basic Benefits Package to the NHC client. While the PCP is responsible for providing the client a medical home and ensuring appropriate health care services, the medical/surgical plan, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the NHC programmatic requirements. In developing its program for the delivery of the Basic Benefits Package, and all related aspects of the NHC, the medical/surgical plan shall incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for the NHC under the Nebraska Medical Assistance Program (NMAP).

The NHC delivers the Basic Benefits Package to Medicaid clients through one or more Health Maintenance Organizations (HMOs) and a Primary Care Case Management (PCCM) Network.

4-002 Primary Care Physician (PCP): The following provisions describe the PCP's responsibilities in the NHC.

4-002.01 Functionality of the PCP: The client chooses or is assigned to a Primary Care Physician (PCP). The PCP is the physician who provides a medical home for the client and is responsible for referrals for all medically necessary services. PCPs may participate in one or all of the HMOs, and/or in the PCCM Network. The PCP must be a Medicaid-enrolled provider (see 482-000-21, Medicaid Provider Enrollment Guide, and 471 NAC 2-000). A specialty care physician may function in an extended capacity with the PCP in certain circumstances with medical/surgical plan approval (see 482 NAC 4-002.02A).

4-002.02 Types of Providers: To participate in the NHC, a PCP must be a primary care physician whose primary expertise is in family practice; general practice; pediatrics; internal medicine; or obstetrics/gynecology, as identified as the primary specialty in the Department's Provider File System. These five specialties will be available for the client to choose as his/her PCP in either the HMO or PCCM Network (see 482-000-22, Provider Network File Guide).

For teaching clinics, the client shall choose the facility's attending physician in the teaching clinic as the PCP, even though the clinic's resident actually provides care to the client. This attending physician shall supervise and approve on all medical care provided to the client.

4-002.02A Designated Specialty Care Physicians: The NHC allows for the designation of appropriate specialists to function in an extended capacity with the PCP for clients with chronic conditions requiring specialty care.

The following procedure applies when a client, PCP, medical/surgical plan, or other person on behalf of the client requests such an arrangement:

1. The requester shall contact the EBS and provide documentation, in the form of a letter, stating the reason(s) for the request;
2. The EBS shall review the documentation and conduct any additional inquiry to clearly establish the reason(s) for request;
3. The EBS shall submit the request to the medical/surgical plan within two days of the request;
4. The medical/surgical plan approves or denies the request within five working days and responds to the EBS, along with written justification in the case of a denial, and alternatives for the client to consider (e.g., expanded consultative services);
5. The EBS shall inform the Department of the medical/surgical plan's decision;
6. The Department shall notify the client of the decision. The medical/surgical plan shall notify the PCP and specialist; and
7. The medical/surgical plan shall monitor the effectiveness of the PCP and specialist in providing continuity of care for the client.

If the request is initiated by or made to the Department, the request will be forwarded to the EBS within five working days.

The request for a designated specialty care physician to function as a PCP must be the decision of the medical/surgical plan. To accommodate the provision, the medical/surgical plan shall allow an open referral between the PCP and specialist, and shall monitor the overall continuity of care. The PCP for the client does not change, only the shared responsibility and ease of referral patterns between the PCP and the designated specialist under the medical/surgical plan’s oversight. The medical/surgical plan shall also consider providing consultative services to the PCP and/or specialist for certain experience-sensitive conditions, e.g., HIV/AIDS.

The designated specialty care physician shall have enhanced responsibilities for clients with special health care needs designated upon review and concurrence of the specialist and the medical/surgical plan. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc.

While this provision is written as an alternative to be utilized by the medical/surgical plan, the Department has a general expectation that the medical/surgical plan shall provide all necessary specialty and consultative services as a matter of practice. This provision is to facilitate a more complex, case-specific, approach for a client with special medical needs.

The medical/surgical plan shall report all such facilitative arrangements to the Department.

4-002.03 Limit on Number of Enrollees: A PCP is allowed to care for no more than 1500 Medicaid clients. When a PCP employs one or more physician extenders (i.e., nurse practitioners, physician assistants, certified nurse midwives, second-year and third-year residents), the PCP may care for up to an additional 500 clients, for a total of 2000 Medicaid clients. This allowable limit is referred to as PCP "slots." PCP limitations will be maintained in the Department's Provider Network File.

4-002.04 PCP Qualifications and Responsibilities: To participate in the NHC, the PCP must:

1. Be a Medicaid-enrolled physician and agree to comply with all pertinent Medicaid regulations;
2. Sign a contract with the medical/surgical plan as a PCP which explains the PCP's responsibilities and compliance with the following NHC requirements:
   a. Treat NHC clients in the same manner as other patients;
   b. Provide the Basic Benefits Package per 471 NAC to all clients who choose or are assigned to the PCP's practice according to the Enrollment Report and comply with all requirements for referral management and prior-authorization;
   c. When medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services, and ensure such services are provided by Medicaid-enrolled providers;
   d. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs clients such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.;
   e. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that shall immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;
   f. Not refuse an assignment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;
   g. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the client's special needs.

h. Request transfer of the client to another PCP only for the reasons identified in 482 NAC 2-003.03 and continue to be responsible for the client as a patient until another PCP is chosen or assigned;
i. Comply with 482 NAC 4-002.05 if disenrolling from participation in the NHC and notify the medical/surgical plan in a timely manner so that an Interim PCP (see 482 NAC 2-003.03E) can be assigned;
j. Maintain a medical record for each client and comply with the requirement to coordinate the transfer of medical record information if the client selects another PCP;
k. Utilize the Enrollment Broker Services and Public Health Nursing components of the NHC (see 482 NAC 2-000 and 3-000) as appropriate;
l. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the client's needs.

Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package and the MH/SA Package (see 482 NAC 4-004.05), and in sharing and coordinating case management activities, is shared by providers in both areas.

A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in the NHC. Each medical/surgical plan shall monitor overall coordination between these two service areas, i.e., medical/surgical and MH/SA. The medical/surgical plan shall ensure the PCP is knowledgeable about the MH/SA Package and other similar services and ensure that appropriate referrals are made to meet the needs of the client;
m. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or notifiable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;
n. Comply with all disease notification laws in the State;
o. Provide information to the Department as required;
p. Inform clients about all treatment options, regardless of cost or whether such services are covered by the Nebraska Medical Assistance Program; and

3. Provide accurate information to the medical/surgical plan in a timely manner so that PCP information can be exchanged with the Department via the Provider Network File (482-000-22).

4-002.05 PCP Disenrollment: A PCP may voluntarily disenroll from NHC. If the PCP is disenrolled from NHC, s/he may remain active as a Medicaid provider on a fee-for-service basis for clients not participating in the NHC if all Department regulations continue to be met. The disenrollment is reported by the medical/surgical plan in the Provider Network File (see 482-000-22).

4-002.05A Interim PCP Assignment: The medical/surgical plan will be responsible for assigning an interim PCP (see 482-000-14) in the following situations:

1. The PCP has terminated his/her participation with the medical/surgical plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care; or
2. The PCP is still participating with the medical/surgical plan but is not participating at a specific location, i.e., change in location only.

In both situations, the medical/surgical plan is responsible for ensuring a smooth transition for the client through the assignment of an interim PCP.

The medical/surgical plan shall immediately notify the client, by mail or telephone, that the client is being temporarily assigned to another PCP within the same medical/surgical plan and the new PCP will be responsible for meeting the client's health care needs until a transfer can be completed and activated by the EBS.

4-002.05A1 Client Notification: The notification sent to client by the medical/surgical plan shall include the following information:

1. Client name, address and Medicaid number;
2. Reason for the change;
3. Name, address and telephone number of the new PCP;
4. Notification that the client has fifteen working days to contact the EBS if s/he wishes to change the temporary PCP assignment and/or affiliation with the medical/surgical plan. If the client does not contact the EBS to effect a change, the temporary PCP will "automatically" become permanent; and
5. Information on how to contact the EBS.

If a PCP changes location, the medical/surgical plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location. The medical/surgical plan shall notify the client of the change in location. If the client is not satisfied with the PCP's new location, s/he can request a new PCP in a different location, within the allowed fifteen days.

Exception: If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the Nebraska Medicaid client, the PCP should be treated as a terminated PCP.

A sample of the Interim PCP Assignment letter is included in 482-000-14). The medical/surgical plan shall utilize a similar format that is approved by the Department.

4-002.05A2 Department and Medical/Surgical Plan Coordination: The actual transfer of the client from the client's current PCP to the medical/surgical plan-designated Interim PCP will be accomplished by the medical/surgical plan and the Department via an exchange of information that will systematically be loaded into the Managed Care File by the Department. This information will be provided by the medical/surgical plan to the Department at the time the client letter is sent out. The Department shall process the transfer immediately upon receipt of the information the first month possible, given system cutoff. The client can change the "interim" transfer at any time by following standard transfer procedures.

If a PCP changes location, the medical/surgical plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location.

If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the client, the PCP will be treated as a terminated PCP.

The Department, based on a termination date on the Provider Network File, shall automatically change the name of the PCP on the NHC Identification (ID) Document, on the Nebraska Medical Eligibility System (NMES), and on the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to indicate "Call your plan" (see 471 NAC). This shall allow the medical/surgical plan to work with the client in applying the interim PCP regulations, if applicable.

If a medical/surgical plan becomes aware of a client's desire to change the PCP and/or medical/surgical plan, the client will be referred to the EBS. The medical/surgical plan may assist the client in contacting the EBS, but shall not be involved in the client's choice.

The EBS is not required to contact the client during the fifteen working days. The fifteen days will be based on the date of the client notification. The actual transfer to the Interim PCP is accomplished by the medical/surgical plan and the Department via an exchange of transfer information that will be systematically loaded into the Managed Care File by the Department. The information will be provided by the medical/surgical plan to the Department at the time the client letter is sent out.

The effective date of transfer to the Interim PCP will be the first month possible, even if this is prior to the fifteen working day notification period.

In situations where a provider changes his/her Medicaid provider number, the medical/surgical plan is not required to notify the client. The Department shall automatically make the change from the old number to the new number, as soon as the number change is identified, i.e., on a nightly basis. NOTE: An automated transfer will occur when a provider changes his/her Medicaid provider number, within the Medicaid provider system. This type of transfer is transparent to the client, if the provider has not made any other changes.

4-003 Managed Care Plan: The NHC delivers the Basic Benefits Package to Medicaid clients through a medical/surgical plan, i.e., one or more Health Maintenance Organizations (HMOs) and one Primary Care Case Management (PCCM) Network. The following provisions describe the medical/surgical plan's responsibilities in the NHC:

4-003.01 General Requirements: The medical/surgical plan is required to comply with, but is not limited to, the following general requirements and as specified in the contract between the Department and the medical/surgical plan:

1. Provide the Basic Benefits Package according to all provisions in 482 NAC 4-000 and 471 NAC and ensure the Basic Benefits Package are provided to clients in the same manner (i.e., in terms of timeliness, amount, duration, quality and scope) as those services provided to the non-managed care Medicaid client;
2. Maintain sufficient numbers of PCP slots to ensure adequate access to clients enrolled in the NHC, notify the Department via the Provider Network Enrollment File prior to the effective date of any PCP change whenever possible and if required, notify the client of an interim PCP (see 482 NAC 4-002.05A);
3. Use only providers enrolled in Nebraska Medical Assistance Program (NMAP) to provide the Basic Benefits Package under the NHC;
4. Provide an appropriate range of services and access to preventive and primary care services in the designated coverage areas, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such a cultural diversity and sensitivity, languages, accessibility to clients with mental, physical and communication disabilities, etc.;
5. Provide services directly or arrange for services through subcontractors;
6. Ensure the PCPs participating in the medical/surgical plan’s network comply with all PCP requirements identified in 482 NAC 4-002.04;
7. Accept the client’s choice of PCP and medical/surgical plan;
8. Provide case management (see 482-000-23, Case Management Requirements);

9. Provide a client handbook to the clients enrolled with the medical/surgical plan, other informational materials about NHC benefits that are easy-to-understand, and a comprehensive list of Primary Care Physicians (PCP's), specialists and ancillary service providers. Maintain written policies and procedures and provide such information to clients in a manner appropriate to the client's needs. The medical/surgical plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by the Department prior to implementation. Note: The PCCM Network is only required to maintain a network of PCPs. In the PCCM Network, the client has access to all specialty and ancillary service providers that are active and enrolled in the Nebraska Medical Assistance Program.

   The medical/surgical plan shall comply with the following marketing guidelines (see 482-000-24, NHC Marketing and Client Information Procedure Guide):
   a. Obtain Departmental approval for all marketing materials;
   b. Ensure marketing materials do not contain any false or potentially misleading information (in a manner that does not confuse or defraud the Department);
   c. Ensure marketing materials are available for the client population being served in the designated coverage areas;
   d. Avoid offering other insurance products as an inducement to enroll;
   e. Comply with federal requirements for provision of information including accurate oral and written information sufficient for the client to make an informed decision about treatment options; and
   f. Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing;
10. Comply with the Department's continuous Quality Assurance/Quality Improvement activities, provide health services meeting the Department's quality standards, and comply with all requests for reports and data to ensure that QA/QI performance measures are met (see 482 NAC 6-000);
11. Meet all requirements of the Americans with Disabilities Act (ADA) and provide appropriate accommodations for clients with special needs. Ensure PCPs and specialists are equipped in appropriate technologies, e.g., TTY/TDD and language services, or are skilled in various languages and areas of cultural diversity/sensitivity, and/or the network is appropriately staffed to ensure an adequate selection for those clients who have special cultural, religious or other special requests;
12. Coordinate activities with the Department, other NHC contractors, and other providers for services outside the Basic Benefits Package, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well managed patient care, including, but not limited to:
    a. Management and integration of health care through the PCP, and coordination of care issues with other providers outside the medical/surgical plan, for services not included in the Basic Benefits Package (e.g., MH/SA services, Pharmacy, Dental Services, etc.), or for services requiring additional Departmental authorization (e.g., sterilization exceptions for age and consent period requirements, abortions, experimental or investigational treatment, HEALTH CHECK (EPSDT) treatment services not covered by the Nebraska Medical Assistance Program, transplants (except corneal), Nursing Facility Services, etc.);

b. Required referral/prior authorization requirements for medically necessary specialty and ancillary services;
c. Provision of or arrangement for emergency medical services, 24 hours per day, seven days per week, including an education process to help assure clients know where and how to obtain medically necessary care in emergency situations;
d. Unrestricted access to protected services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;
e. Clearly identified expectations for the PCPs, subcontractors and any other service providers participating in the client's managed care and documentation of that care for quality assurance/quality improvement purposes;
f. Retention of plan-maintained records and other documentation during the period of contracting, and for three years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original three year period ends; and
g. Adequate policy regarding the distribution of the client's medical records if a client changes from one PCP to another, or from one medical/surgical plan to another according to Department specifications;

13. For an HMO only, whenever possible, the HMO shall use State-designated laboratories to ensure that lab results that involve infectious or notifiable diseases or diseases for which there are registries maintained by Federal, State and Local public health agencies. The Department shall require the HMO to work cooperatively with the public health agencies to share appropriate service data and participate in other similar preventative and data collection initiatives that may be promoted by the Department and public health agencies. The laboratories utilized by the medical/surgical plan shall comply with the Clinical Laboratory Improvement Act (CLIA);
14. Comply with regulations providing for advance directives;
15. Not refuse an enrollment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;
16. Require that all subcontractors meet the same requirements as are in effect for the medical/surgical plan that are appropriate to the service or activity delegated under the subcontract;
17. Provide Member services;
18. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
19. If an HMO, provide for a Physician Incentive Program (PIP) only if:
    a. No specific payment is made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a client;

b. The medical/surgical plan provides PIP information to any Medicaid client, upon request, and the medical/surgical plan includes a statement on its marketing materials disclosing the client's right to adequate and timely information to related physician incentives;
c. The medical/surgical plan does not have PIPs placing a physician or physician group at substantial financial risk for the cost of services;
d. Where appropriate, the physician or physician group provides adequate stop-loss protection to the individual physicians; and
e. Where appropriate, the medical/surgical plan conducts client surveys;

20. Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;
21. Prohibit discrimination against providers based upon licensing;
22. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
23. For an HMO only, ensure adequate numbers of medical specialists in its network to meet the needs of its members. Clients with chronic or severe medical conditions, e.g., HIV/AIDS, will be allowed to go directly to a qualified specialist within the medical/surgical plan's network;
24. Ensure that PCPs inform clients about all treatment options, regardless of cost or whether such services are covered by the medical/surgical plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does not require a medical/surgical plan to cover counseling or referral if it objects on moral or religious grounds and makes available information regarding policies to clients who are enrolled with the medical/surgical plan, or who may enroll with the medical/surgical plan, within ninety days of a policy change regarding such counseling or referral services;
25. Provide written notice to the client of any adverse action (i.e., denial or reduction) regarding the provision of services that complies with all federal and state requirements, as described in the NHC Marketing and Client Information Procedure Guide (see 482-000-23). Allow clients to challenge decisions to deny, limit or terminate coverage of services. Clients shall be allowed to file complaints, grievances and appeals, according to 482 NAC 6-000;
26. Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 the maternity length of stay and mental health parity requirements specifically requiring coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six hours for both the mother and newborn child;
27. For an HMO only, provide assurances that any amount expended for home health care services be provided with the appropriate surety bond;
28. Report all fraud and abuse information to the Department;

29. For an HMO only, comply with the provisions of 482 NAC 4-003.04 for provider payments; and
30. Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of the NHC, and any other activities deemed appropriate by the Department and supported in regulations and/or contractual amendments;
31. Comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-003.02 HEALTH CHECK (EPSDT): The medical/surgical plan shall develop a program to ensure the delivery of HEALTH CHECK (i.e., Early and Periodic Screening, Diagnosis and Treatment or EPSDT services).

HEALTH CHECK (EPSDT) is a priority for the NHC, and, as such, should be emphasized whenever appropriate and feasible with families who have children age twenty (20) and the younger. The medical/surgical plan shall contact HEALTH CHECK (EPSDT) eligible children within sixty days of enrollment and encourage them to make an appointment for a health and dental screening. The required components are health screening, including medical, vision, hearing and dental screening (see 471 NAC 33-000). The medical/surgical plan must also counsel the family regarding the importance of health supervision and regular check-ups and assist in removing barriers to care. If necessary, the medical/surgical plan assist families with appointment scheduling and transportation.

At a minimum, efforts shall include:

1. HEALTH CHECK (EPSDT) Screening: The medical/surgical plan shall provide HEALTH CHECK (EPSDT) services according to 471 NAC Chapter 33-000.
    a. The medical/surgical plan shall outreach to HEALTH CHECK (EPSDT) eligible children who need to be scheduled for HEALTH CHECK (EPSDT) examinations. Targeted groups are -
        (1) Newly Medicaid-eligible and other children who have not had a timely HEALTH CHECK (EPSDT) examination;
        (2) Children who have been identified as not having ever been screened or not having received HEALTH CHECK (EPSDT) services within established timelines based on the periodicity schedule; and
        (3) Children from birth to the second birthday, particularly infants and toddlers that may need immunizations, lead level testing, developmental testing and hearing testing.
    b. The medical/surgical plan may contact the EBS regarding -
        (1) Screening appointments missed without cancellation to determine the barriers to care, to assist in rescheduling the appointment, and to counsel the family about keeping appointments; and
        (2) Screening results from a referral for treatment and the client who does not follow up with treatment services as identified by the medical/surgical plan.

c. The medical/surgical plan shall assist the PCP to establish a recall system for HEALTH CHECK (EPSDT) examinations. The recall systems may provide notification through phone call or post card. The medical/surgical plan may substitute their recall system in place of the PCP's; and

d. The medical/surgical plan shall use continuous quality improvement methods to achieve a performance goal of HEALTH CHECK (EPSDT) screens at the recommended participation rate, according to the contract with the Department.

2. The medical/surgical plan must provide HEALTH CHECK (EPSDT) screens at a recommended participation rate of at least five percent greater than the rate by age reported in the CMS-416 Annual EPSDT Report for FY1996 for the first contract year and shall increase at a rate of five percent per year thereafter until eighty percent or until the most current CMS participation goal in the aggregate is reached. Measurement will be done according to the methodology of the CMS-416.

3. If a client requests a HEALTH CHECK (EPSDT) screen for the initial screen, the medical/surgical plan shall provide the screening examination(s) within sixty days. Subsequent screening exams (including vision and hearing, medical and referral for dental) are to be provided according to the periodicity schedule, or an interperiodic examination if appropriate. The minimum schedule of health screening examinations is the "Recommendations for Preventive Pediatric Health Care" published by the American Academy of Pediatrics.

4. The medical/surgical plan is responsible for the administration of immunizations per the standardized Periodicity and Immunization Schedules. All PCPs, as appropriate, shall participate in the Vaccines for Children (VFC) program to provide childhood immunizations to Medicaid eligible children.

   The VFC program was established to ensure that children will have access to childhood immunizations and the protection they provide. The requirements of the VFC program administered will be reported with the appropriate procedure code and modifier to identify them as VFC vaccine immunizations.

   Vaccine not available through the VFC program, but recommended and published by the Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics shall be provided and reimbursed by the medical/surgical plan to the PCP. The medical/surgical plan is to promote increasing immunization levels to reach the State's Healthy 2000 immunization level goals.

   Immunization administration for VFC vaccines shall be paid by the medical/surgical plan to any public health provider whether s/he is in the medical/surgical plan's network or not.

5. The PCP and medical/surgical plan shall take a proactive approach to ensure clients obtain HEALTH CHECK (EPSDT) screening services and medically necessary diagnosis and treatment services. A proactive approach includes:
   a. For an HMO only, written notification and phone protocols for upcoming or missed appointments within a set period of time;
   b. Protocols for conducting outreach with non-compliant members;
   c. Outreach and follow-up to children with special health needs, e.g., children in foster care, pregnant adolescents;
   d. For an HMO only, provision of demographic information to public health agencies when HEALTH CHECK (EPSDT) screening identifies children with elevated blood lead levels (EBLL); and
   e. Referrals to public health agencies for environmental assessments and caregiver education services for children with lead poisoning.
6. Medically necessary treatment will be provided according to 471 NAC 33-000; e.g., diagnosis and treatment, covered by the Nebraska Medical Assistance Program, federally defined and medically necessary, to treat, prevent or ameliorate a condition; to promote growth and development; to attain or maintain functional status; or prevent deterioration. Treatment services also include rehabilitative and habilitative services for HEALTH CHECK (EPSDT) eligible children. The medical/surgical plan must provide information and referral in addressing social, educational, and other health needs as requested. Refer requests for treatment not covered by the Nebraska Medical Assistance Program to the Department.
7. Throughout the contract term, participate in the NHC Quality Assurance Plan's ongoing maternal and child health-related activities, including those supporting the Health and Human Services regulations and licensure's grant under maternal and child health programs and activities. The medical/surgical plan shall cooperate with the Department's Title V, Maternal Child Health Program (MCHP), in, but not limited to, the following activities:
   a. Training regarding new public health measures and standards;
   b. Working together to develop strategies to communicate with hard to reach and high risk populations;
   c. Contracting with Title V providers and Title X clinics, whenever feasible, for evaluations and treatment services;
   d. Sharing medical information with the Medically Handicapped Children's Program (MHCP) for children receiving services through MHCP and the medical/surgical plan;
   e. Developing arrangements with MHCP regarding specialty care through MHCP team clinics in the best interests of the child;
   f. Coordinating with other services, e.g., WIC, PART H school-based services, as appropriate;

g. Cooperating with public health agencies who have identified children with abnormal lead levels. The medical/surgical plan will provide:
   (1) Lead screening and blood lead testing according to the Center for Disease Control (CDC) and CMS requirements;
   (2) Provide information to PCPs regarding the provision of blood lead screening and testing; provide information regarding coverage of environmental investigation;
   (3) Encourage collaboration and communication with public health lead prevention programs; and
   (4) For an HMO only, utilize and reimburse laboratories under contract with public health lead prevention programs to perform blood level testing.

   The medical/surgical plan shall not require a PCP or medical/surgical plan approval to receive reimbursement for specimens sent to the laboratories by public health agencies; and

h. For an HMO only, coordinating with public health immunization clinics regarding immunization reporting.

8. Using pediatric specialists for children where the need for pediatric specialty care is significantly different from the need for adult specialists, e.g., pediatric cardiologist for children with congenital heart defects.

4-003.03 Third Party Liability (TPL) Requirements: The medical/surgical plan shall utilize a cost avoidance methodology whenever there is a verified third party resource (TPR). For an HMO, the medical/surgical plan shall assume responsibility for all TPL requirements. For the PCCM Network, all TPL requirements are completed by the Department. The following parameters apply:

1. The medical/surgical plan, its subcontractors or providers, shall actively pursue, collect, and retain any monies from third party payers for the usual and customary charges on covered services to clients except when the amount of reimbursement the medical/surgical plan can reasonably expect to receive is less than the estimated cost of recovery; and
2. The medical/surgical plan, its subcontractors or providers, may, at their sole discretion, compromise a claim against a third party payer, or may elect not to pursue the claim if they determine it is not cost effective to do so. The Department shall provide whatever assistance or assignments, as are necessary, to aid in the medical/surgical plan's collection efforts. Any recoveries by the medical/surgical plan shall not affect continued payment of capitation for that client as long as the client remains enrolled in the NHC.

The Department has assigned to the medical/surgical plan, or its subcontractors or providers, all rights to recover payments from third parties as provided by state law, in its contract with the medical/surgical plan. TPL refers to any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a client. Under federal law, the Department is required to identify legally liable third parties and treat the verified third party as a resource of the client. The medical/surgical plan, its subcontractors or its providers shall not pursue collection from the client but directly from the liable third party payers, except as allowed in 468 NAC, 469 NAC, and 477 and 480 NAC.

TPL includes, but is not limited to:

1. Health insurance (private or group, including ERISA);
2. Casualty insurance;
3 Medicare;
4. Workers' Compensation;
5. Other federal program unless excluded by statute, such as Indian Health Service programs and Migrant Health programs; and
6. Any other party legally obligated to pay medical expenses.

The medical/surgical plan agrees to:

1. Take responsibility for pursuing TPL for clients in the above categories;
2. Make reasonable attempts to identify TPR within its existing resources, but the primary responsibility for identifying TPR and communicating that information to the medical/surgical plan is with the Department or its designee. The Department shall retain the responsibility for collecting the medical support from absent parents;
3. Provide available information to, and cooperate with, the Department in its effort to collect those resources;
4. To track its TPL recoveries for its enrolled clients and to report these recoveries to the Department using the guidelines listed below. The Department shall supply the medical/surgical plan with available TPL information for enrolled clients on the monthly enrollment report;
5. Maintain records of all third party recoveries and report this recovery activity to the Department on a monthly basis in a form and manner agreeable to both parties. The medical/surgical plan's recovery activity report shall detail any recovery activity taken by the medical/surgical plan against any of the TPR. Activity shall include, but is not limited to:
   a. Filing a lien,
   b. Submitting a bill,
   c. Receiving payment,
   d. Working with a client's legal representative, and/or
   e. Receiving a denial from a TPR;
6. On claims paid by the medical/surgical plan, submit claims to health insurers within sixty days following notification of an available TPR;
7. In a liability situation, file a lien if lawfully permitted, within thirty days following notification of the available liability resource; and
8. Notify the Department of clients who refuse to assist the medical/surgical plan and the Department in enforcing TPL recovery.

(See 482-000-25, TPL Procedure Guide.)

4-003.04 Provider Payments Participating in an HMO: The following provisions apply:

4-003.04A Timeliness of Provider Payments: The medical/surgical plan shall provide payment to a provider of services on a timely basis, consistent with Medicaid claims payments procedures and the minimum standards provided below, unless the health care provider and organization agree to a capitated payment schedule or other arrangement.

The medical/surgical plan shall provide an information system that includes the capability to electronically accept claims for adjudication and make payments in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such electronic system shall have the ability to transmit data to a central data repository which complies with the requirements for confidentiality of information under the Medicare program.

The medical/surgical plan shall comply with the following minimum timeframes for the submission and processing of clean claims. Timeframes are calculated from the day the clean claim is received by the medical/surgical plan until the date of the postmark that either returns the claim to the provider or until posted on a electronic system.

All "clean" claims were to be adjudicated (i.e., paid, denied, or have the deductible applied to them) within 30 days from the date of receipt.

4-003.04A1 Prompt Investigation and Settlement of Claims: The medical/surgical plan shall comply with the requirements related to claim forms as set forth in 471 NAC. This shall include the use of Form CMS-1500, Health Insurance Claim Form and the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for providers of outpatient services and Form CMS-1450 (UB-92) and the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) for hospitals providing inpatient or outpatient services. Any claim forms or submission methodology developed by the medical/surgical plan for use by the providers shall be approved by the Department and must be in a format as to assure the submission of authorization and claims data.

4-003.04A2 Definitions: For purposes of 482 NAC 4-003.04, the following words shall have the following meanings, unless the context clearly indicates otherwise:

"Claims" means a request for payment for service rendered or supplies provided by the provider to a client.

"Clean Claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstances requiring special treatment that otherwise prevents timely payment being made on the claim.

"Returned Claim or Contested Claim" means a claim that has not been adjudicated because it has a material defect or impropriety.

4-003.04A3 System Requirement: The medical/surgical plan shall establish and maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identified of the office handling the claim on behalf of the medical/surgical plan.

4-003.04A4 Payment Standard: The medical/surgical plan shall pay clean claims promptly as provided above after the date the medical/surgical plan receives written or electronic notice of the claim. If, for whatever reason, the claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the medical/surgical plan shall calculate the maximum thirty day period.

4-003.04A5 Notice of Contested Claim: The medical/surgical plan shall provide written or electronic notice to the provider of a determination by the medical/surgical plan that the claim is a contested claim with the returned claim. The written or electronic notice shall comply with the provisions in 482 NAC 4-003.04.

4-003.04A6 Notice Requirement for Partially Contested Claim: If the medical/surgical plan determines that part of a claim is a contested claim and returns the claim, the medical/surgical plan shall provide written or electronic notice of that determination to the person submitting the claim and shall proceed to pay the portion of the claim determined by the medical/surgical plan to be a clean claim promptly, but no later than thirty calendar days following the date that the medical/surgical plan receives the written or electronic notice of claim.

4-003.04A7 Prohibited Action: In no instance shall the medical/surgical plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the medical/surgical plan's ability to adjudicate the claim.

4-003.04A8 Notice of Insufficient Information: If the medical/surgical plan determines that a claim provides insufficient information for the medical/surgical plan to pay the claim, the medical/surgical plan shall provide written or electronic notice of this determination to the person submitting the claim or member, if different from the person submitting the claim, promptly but in no instance later than thirty calendar days following the date that the medical/surgical plan receives written or electronic notice of the claim, including the following information:

1. All of the reasons for the denial of the claim;
2. The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and
3. The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his/her areas code.

4-003.04A9 Effective Notices and Payments: Written notice of a claim shall be effective upon the date that the claim is received at the address provided by the medical/surgical plan to the providers for receipt of claims of the type submitted. However, if the provider and the medical/surgical plan agree to administer claims by electronic transmission, the medical/surgical plan shall have constructive notice of the claim as of the date the claim is posted to the electronic transfer system.

Payment from the medical/surgical plan shall be effective as of the date that:

1. A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly address, postage-paid envelope;
2. The date the medical/surgical plan posts the item to an electronic transfer system; or
3. The date of delivery of the draft or other valid instrument equivalent to payment if 1 or 2 do not otherwise apply.

Payment and notices distributed by a medical/surgical plan's subcontractor shall be effective when made in compliance with this section, as appropriate.

Notices from the medical/surgical plan shall be effective as of the date that the notice is:

1. Placed in the United States mail in a properly addressed, postage paid envelope;
2. Posted to an electronic system; or
3. Delivered if 1 or 2 do not otherwise apply.

4-003.04A10 Contents of a Notice of a Contested Claim: The medical/surgical plan shall specify in its notice of a returned claim at least the following information:

1. The name, address, telephone number and facsimile number of the office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitted the claim, or provider should communicate to resolve problems with the claim;
2. The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the medical/surgical plan;
3. The specific information needed by the medical/surgical plan to make a determination that the claim is a clean claim; and
4. The date the claim was received.

In addition, the medical/surgical plan shall include in a notice regarding a claim that the medical/surgical plan has determined in part a contested claim, a statement specifying those portions of the claim that are considered to be clean claim, and the amounts payable with respect to the clean claim portion.

Requests for information made by the medical/surgical plan on a contested claim shall be reasonable and relevant to the determination of whether the claim is a clean claim or claim that shall be denied.

The medical/surgical plan and the Department shall agree upon a form for the information necessary to satisfy the requirements of 482 NAC 4-003.04.

4-003.04A11 Use of Intermediaries: A medical/surgical plan's use of subcontractors to perform one or more of the medical/surgical plan's claims handling functions shall not in any way mitigate a medical/surgical plan's responsibility to comply with all of the terms of 482 NAC.

4-003.04A12 Electronic Remittance Advice: Electronic remittance advice shall be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-003.04A13 Claim Status Inquiry and Response: Electronic claim status inquiry and response shall be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-004 Basic Benefits Package General Provisions: All services provided under the NHC must meet the requirements of 471 NAC unless specifically waived by the Department. The PCP and medical/surgical plan shall apply the same guidelines for determining coverage of services for the NHC client as the Department applies for other Medicaid clients. Actual provision of a service included in the Basic Benefits Package must be based on whether the service could have been covered under the Nebraska Medical Assistance Program on a fee-for-service basis under Title 471 NAC.

Copayments are not required for clients enrolled in NHC, with the exception of prescription drugs or other Medicaid-covered services not included in the Basis Benefits Package. Copayments are not required for Mental Health/Substance Abuse (MH/SA) services for clients enrolled in the NHC, except for services not included in the MH/SA Package.

All services in the Basic Benefits Package must be provided or approved by the PCP and medical/surgical plan. The PCP must be a Medicaid-enrolled provider. (If an HMO, the plan may provide a non-Medicaid coverable service if the service is provided by a non-Medicaid enrolled provider.)

In addition to the PCP and medical/surgical plan provision/approval, the following services must be prior authorized by the Department:

1. HEALTH CHECK (EPSDT) treatment services not covered by the State Plan (see 471 NAC);
2. Abortions (see 471 NAC);
3. Transplants (see 482 NAC 2-004); and
4. Sterilization Exceptions (see 471 NAC).

Family planning services (see 482 NAC 4-004.03), emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by the PCP and medical/surgical plan. All covered emergency services (see 482 NAC 4-004.04) will be available 24 hours per day, seven days per week, and shall not be limited to plan-affiliated providers. The client may access these services from any Medicaid-enrolled provider s/he chooses, and is not limited to providers within the medical/surgical plan's network. The client may access these services without a referral, even if the medical/surgical plan contracts with Medicaid to provide these services.

The Department requires the medical/surgical plan to reimburse providers, network and out-of-network, for appropriate medical screening performed during an emergency room visit. The payment of claims to out-of-network providers are subject to the requirements in 482 NAC 4-003.04.

Electronic referral/authorization shall be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-004.01 Services in the Basic Benefits Package: Services included in the Basic Benefits Package:

1. Inpatient hospital services (see 471 NAC 10-000);
2. Outpatient hospital services (see 471 NAC 10-000);
3. Clinical and anatomical laboratory services, excluding laboratory services related to Mental Health/Substance Abuse (MH/SA) (see 471 NAC 10-000 and 18-000);
4. Radiology services, excluding radiology services related to MH/SA (see 471 NAC 10-000 and 18-000);
5. HEALTH CHECK (Early Periodic Screening and Diagnosis and Treatment as federally mandated) services (see 471 NAC 33-000 and 482 NAC 5-003.02);
6. Physician services, including nurse practitioner services, certified nurse midwife services, and physician assistant services, anesthesia services including a Certified Registered Nurse Anesthetist, excluding anesthesia for MH/SA (see 471 NAC 18-000 and 29-000);
7. Home health agency services (see 471 NAC 14-000). (This does not include non-home health agency approved Personal Care Aide Services under 471 NAC 15-000);
8. Private duty nursing services (see 471 NAC 13-000);
9. Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology (see 471 NAC 14-000, 17-000, and 23-000);
10. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (see 471 NAC 7-000 and 8-000);
11. Podiatry services (see 471 NAC 19-000);
12. Chiropractic services (see 471 NAC 5-000);
13. Ambulance services (see 471 NAC 4-000);
14. Medical transportation services (see 471 NAC 27-000) (Note: Clients participating in the PCCM Network receive non-urgent medical transportation through the Department);
15. Visual services (see 471 NAC 24-000);
16. Family Planning services (see 471 NAC 18-000 and 482 NAC 5-004.03);
17. Emergency services (see 471 NAC 10-000 and 482 NAC 5-004.04);
18. Coordinated MH/SA services (see 471 NAC 20-000 and 32-000 and 482 NAC 4-004.05);
19. Federally Quality Health Center (FQHC), Rural Health or Tribal Clinic services (see 471 NAC 11-000, 29-000, 34-000 and 482 NAC 4-004.06);
20. Certified Nurse Midwife services (see 471 NAC 18-000 and 482 NAC 4-004.07);
21. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12-000, 13-000 and 482 NAC 2-004.04);
22. Transitional Hospitalization services (see 471 NAC 10-000, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A); and
23. Transitional Transplantation services (see 471 NAC 10-000 and 482 NAC 2-004).

Medicaid regulations governing coverage of these services are contained in 471 NAC.

The services above represents covered services under the Nebraska Medical Assistance Program (NMAP). The medical/surgical plan is responsible for working with the Department to ensure the client has access to all services.

The medical/surgical plan shall provide the above services in amount, duration and scope defined by the Department in 471 NAC. The medical/surgical plans shall provide care and services when medically necessary to ensure the client receives necessary services. The medical/surgical plan shall also ensure that the services provided to the client are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client.

In the interest of providing comprehensive services to the client, the medical/surgical plan shall provide medically necessary services to the client that are in addition to those covered under the NMAP. If additional services are provided, the total payment to the medical/surgical plan shall not be adjusted but shall remain within the rates agreed upon in any resulting contract.

4-004.02 NHC Excluded Services: The following Medicaid-coverable services are excluded from the NHC Basic Benefits Package, and are not the responsibility of the medical/surgical plan:

1. Pharmacy Services (471 NAC 16-000);
2. Nursing Facility Services - custodial level of care (see 471 NAC 12-000 and 482 NAC 2-004.04);
3. ICF/MR services (see 471 NAC 31-000);
4. Home and community based waiver services (see Title 480 NAC);
5. School-based services covered under Medicaid in Public Schools (see 471 NAC 25-000);
   Note: The medical/surgical plans are still required to operate a program to improve the quality of and access to health care services for children and adolescents through coordination with school-based services;
6. Optional targeted case management services (see Title 480 NAC);
7. Mental Health/Substance Abuse (MH/SA) Services (see 471 NAC 20-000 and 32-000), except as addressed in 482 NAC 5-000;
8. Dental (see 471 NAC 6-000);
9. Lab and anesthesia related to MH/SA (see 471 NAC 20-000 and 32-000); and
10. Non-Home Health Agency Approved Personal Care Aide Services (471 NAC 15-000).

These services are paid on a fee-for-service basis. Clients shall access these services through the NMAP (i.e., 471 NAC or 480). However, provision of these services by the Department may require referral, management and coordination by the client's PCP, if the client is enrolled in the NHC. For all Medicaid-covered services, the PCP and medical/surgical plan is required to coordinate the client's care to promote continuity of care for the client.

The medical/surgical plan and EBS shall inform the client of the availability of these services and how to access them.

4-004.03 Family Planning Services: Approval by the client's PCP and medical/surgical plan is not required for family planning services. The EBS shall inform NHC clients their freedom of choice for family planning services is not restricted to a provider participating in the NHC but that they must use a Medicaid enrolled provider.

Family planning services are services to prevent or delay pregnancy, including counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. This includes tubal ligations and vasectomy. Treatment for sexually transmitted diseases (STD) is to be reimbursed by the medical/surgical plan in the same manner as family planning services, without referral or authorizations by the PCP and medical/surgical plan. STD includes but is not limited to Chlamydia, Gonorrhea and Syphilis.

This does not include hysterectomies, other procedures performed for a medical reason, (such as removal of an intrauterine device due to infection) or abortions.

Family planning services are to be paid by the medical/surgical plan even if the provider is not part of the medical/surgical plan's network.

4-004.04 Emergency Services: Prior-approval by the client's PCP and medical/surgical plan is not required for receipt of emergency services. The EBS shall inform NHC clients that PCP and medical/surgical plan approval of emergency services is not required and shall educate clients regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the client to contact the PCP and medical/surgical plan before accessing emergency services

4-004.04A Emergency Services Provided to NHC Clients: The medical/surgical plan has no obligation to pay for emergency services unless the provider of the emergency services submits a bill within ninety calendar days of the date services were provided.

If the medical/surgical plan has reasonable basis to believe any covered services are claimed to be emergency services were not in fact emergency services, payment may be denied for the services; provided that within ninety calendar days of receipt of a claim for payment:

1. The provider of the services is notified of the decision to deny payment, the basis for that decision, and the provider's right to appeal that decision by requesting a hearing (see 482 NAC 6-002.01);
2. The client is notified of the decision to deny payment, the basis for that decision, and the client's right to appeal (see 482 NAC 6-002); and
3. The medical/surgical plan shall provide a triage or medical screening fee to determine if a medical emergency exists.

The medical/surgical plan shall comply with and implement any Departmental hearing decision, subject to any further rights to appeal.

An emergency medical condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, b) serious impairment to such person's bodily functions, c) serious impairment of any bodily organ or part of such person.

4-004.05 Mental Health/Substance Abuse (MH/SA) Coordination Issues: The following rules apply when coordination of services is required between the medical/surgical plan responsible for the Basic Benefits Package and the MH/SA plan responsible for the MH/SA services, as addressed by the Department in regulations governing both components of the NHC. In situations where the client isn't participating in both components of the NHC, the associated service is coordinated with the Nebraska Medicaid Assistance Program on a fee-for-service basis.

4-004.05A Emergency Room Services for MH/SA Services: Emergency room services provided to a client who is participating in the MH/SA component of the NHC is the responsibility of the client's medical/surgical plan regardless of the client's final or principle diagnosis.

At the time a MH/SA provider initiates an evaluation and/or treatment for the client, the medical/surgical plan is no longer responsible for MH/SA related service. Authorization for MH/SA services from that point forward must be obtained from the MH/SA plan.

4-004.05B Admissions for 24-Hour Observation: When a client who is participating in the MH/SA component of the NHC is admitted to an acute care (i.e., medical/surgical) facility as an outpatient for 24-hour observation (for purposes of a MH/SA diagnosis), the MH/SA plan is responsible for payment of the observation stay. Authorization for the admission must be obtained from the MH/SA plan.

The MH/SA plan is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the client and determines that the client does not have a MH/SA diagnosis. Authorization for medical/surgical services from that point forward must be obtained from the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

4-004.05C Chemical Detoxification Services and Substance Abuse Treatment: Chemical detoxification is a covered service for clients of any age. Authorization for hospital admissions must be obtained from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Substance abuse treatment services are covered for Medicaid-eligible clients age 20 and the younger only. Allowable substance abuse services for a client must be authorized by the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

4-004.05D History and Physical (H&P) Exams for Inpatient Admissions for MH/SA Services: The H&P completed for an inpatient admission for MH/SA services is the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC. The physician completing the H&P must obtain authorization from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Inpatient MH/SA services provided to clients participating in the MH/SA component of the NHC in a freestanding or hospital-based residential treatment center (RTC), treatment group home are the responsibility of the MH/SA plan. H&Ps provided to NHC clients for these allowable services are responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

4-004.05E Ambulance Services for NHC Clients Receiving MH/SA Treatment Services: Emergency medical transportation, regardless of diagnosis or condition is the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

All other medically necessary ambulance services are the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Non-ambulance and non-emergency medical transportation for MH/SA services is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

4-004.05F Injections Associated with MH/SA Services: Injections of psychotropic drugs, such as Haldol and Prolixin, in an outpatient setting, are the responsibility of the client's MH/SA plan, if the client is participating in the MH/SA component of the NHC.

4-004.05G Lab, X-Ray and Anesthesiology Associated with MH/SA Services: Services associated with the treatment of MH/SA services and authorized by a MH/SA provider participating in the MH/SA plan’s network, such as lab fees, x-ray charges and the administration of anesthesiology, is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

4-004.06 Federally Qualified Health Centers (FQHC): The medical/surgical plan shall contract with any FQHC located within the designated coverage area or otherwise arrange for the provision of FQHC services. If an FQHC is reimbursed by the medical/surgical plan on a fee-for-service basis, it cannot pay less for those services than it pays other providers. FQHC's electing to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the FQHC requests reasonable cost reimbursement, the medical/surgical plan must reimburse the FQHC at the same rate it reimburses its other subcontractors. A medical/surgical plan that contracts with a FQHC shall report to the Department the total amount paid to each FQHC as specified in the contract. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

In the NHC, the client chooses to participate with the FQHC by selecting the physician as his/her PCP.

The same reasonable efforts that are applied to the FQHC, apply to the Rural Health Clinics and Tribal Clinics.

4-004.07 Certified Nurse Midwife Services: A certified nurse midwife may contract directly with the medical/surgical plan or the client must be informed in writing that the services are available outside the medical/surgical plan on a fee-for-service basis.

4-005 Payment for Services: The following provisions apply for payment of services provided by the medical/surgical plan.

For an HMO, this shall be a capitated payment (see 482 NAC 4-005.03).

For the PCCM Network, this shall be the per member month (PCCM) payment to the PCCM Network Administrator, and to the PCP (see 482 NAC 4-005.04).

4-005.01 Enrollment Report: On or before the first day of the enrollment, the Department shall provide to the medical/surgical plan a monthly enrollment report that lists all enrolled and disenrolled clients for the enrollment month. This report will be used as the basis for the monthly payments to the medical/surgical plan. The medical/surgical plan is responsible for payment of all services in the Basic Benefits Package provided to clients listed on the enrollment report generated for the month of coverage. Any discrepancies between the client's NHC Identification (ID) Document or any identification issued by the medical/surgical plan and the enrollment report must be reported to the Department for resolution. The medical/surgical plan shall continue to provide and authorize services for the client until the discrepancy is resolved. If an eligible client is not listed on the enrollment report, the Department will be responsible for all medical expenses (see 482 NAC 2-002.05.)

4-005.02 Coverage for Pregnant Women/Newborns: Coverage for a pregnant woman and/or the unborn/newborn is provided within the following parameters:

1. Pregnant Woman and Unborn/Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs; and for the unborn/newborn from the month of expected birth until disenrollment occurs. Payment to the medical/surgical plan is made for the month(s) of enrollment for the pregnant woman and the unborn/newborn until disenrollment occurs.
2. Only the Unborn/Newborn is Medicaid Eligible: Coverage is provided for the pregnant woman through the eligibility/enrollment of the unborn/newborn from the month of enrollment until disenrollment occurs. Coverage for the mother and newborn is provided for the month of expected birth through the month in which the 60th day following the month of expected birth occurs. Coverage for only the newborn continues past the 60-day postpartum period as long as the newborn remains eligible and enrolled. Payment to the medical/surgical plan is made for the month(s) of enrollment and/or coverage for the pregnant woman and the unborn/newborn until disenrollment occurs. (See 482-000-26, Pregnancy-Related Procedure Guide.)

In both situations, the medical/surgical plan is responsible for providing pregnancy-related services as defined by the Department for both the mother and unborn/newborn.

4-005.03 Payment for NHC Services - HMO: The Department pays a monthly capitation fee to the medical/surgical plan for each enrolled client for each month of NHC coverage. The monthly capitation fee includes payment for all services in the Basic Benefits Package.

The medical/surgical plan shall provide payment to providers for services rendered on a timely basis, consistent with Medicaid claims payment procedures, unless the health care provider and organization agree to an alternative payment schedule.

Payment to the medical/surgical plan is payment in full for all services included in the Basic Benefits Package. No additional payment may be requested of the Department or the client.

These rates are actuarially determined and are based on geographic location, eligibility category, gender, age and type of services. The Department shall adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any changes in the Upper Payment Limit, Medicaid fee-for-service (FFS) rates, or in instances where the an error or omission in the calculation of the rates has been identified.

4-005.04 Payment for NHC Services - PCCM: The Department pays a per member per month (PMPM) administrative fee to the PCCM Network Administrator and a primary care case management fee to the PCP for each enrolled client for each month of NHC coverage. The monthly fee does not include payment for services in the Basic Benefits Package - claims payment is the responsibility of the Department on a fee-for-service basis.

4-005.05 Recoupments/Reconciliation: The Department shall not normally recoup payments from the medical/surgical plan. However, in situations where payments are made incorrectly, the Department shall work with the medical/surgical plan to identify the discrepancy and shall recoup or reconcile such payments (see 482 NAC 2-002.05).

4-005.06 Billing the Client: The medical/surgical plan may not bill a client for a Medicaid coverable service, regardless of the circumstances.

The provider of service may only bill the client pursuant to 471 NAC.

The medical/surgical plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. Whether the medical/surgical plan is responsible to pay the provider is determined by the agreement the medical/surgical plan has with that provider. In some cases, the provider may not get paid.

Note: The medical/surgical plan is not required to pay a non-Medicaid enrolled provider for a Medicaid-covered service.